

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01363

Reg. Dist. No.

1430

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle Barnes Last Barnes		4. DATE OF DEATH Month Feb. Day 10 Year 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Klondike, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Barnes		14. MOTHER'S MAIDEN NAME Meriam Steele Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT (George Eichhorn) Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary artero sclerosis Conditions, if any, which gave rise to immediate cause (b) ? (c) ? DUE TO ? cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lonaconing, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 11-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONA CONING, MD.		24a. REC'D BY REGISTRAR FEB 18 '58	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

FEB 18 1963

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1431

CERTIFICATE OF DEATH

01364

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Savage</u> LENGTH OF STAY (In this place) <u>Life</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Savage</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas B. Birmingham</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 20, 1958</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 10, 1877</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroading</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Albert Birmingham</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett McMahon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>712-14-1527</u>		17. INFORMANT & ADDRESS <u>James Birmingham, Mt. Savage, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <u>Arterio Sclerosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Senility</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 1958</u> , to <u>Feb 20, 1958</u> , that I last saw the deceased alive on <u>Feb 1, 1958</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Wm C Lane</u> M.D. <u>Frederick M D</u> ADDRESS (Street, city, town, state) <u>Hyndman, Pa.</u> DATE SIGNED <u>Feb 21 1958</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mount Savage, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>		REGISTRAR'S SIGNATURE <u>Wm C Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Zenger</u>		ADDRESS <u>Hyndman, Pa.</u>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

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BUREAU V. S.

FEB 25 1959

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SHORT-CUTS

1. The purpose of this form is to provide a uniform method of recording the facts of death in Maryland. It is to be filled out by the physician or other qualified person who has attended the deceased, or by the funeral director or other person who has been in attendance at the death. The form is to be filed with the local health officer, who will forward it to the State Department of Health. The form is to be filled out in ink, and the entries should be made in the spaces provided. The form is to be filled out in the following order: 1. Name of deceased, 2. Sex, 3. Age, 4. Date of birth, 5. Place of birth, 6. Occupation, 7. Cause of death, 8. Place of death, 9. Time of death, 10. Signature of physician, 11. Signature of registrar, 12. Signature of witnesses, 13. Signature of funeral home, 14. Signature of burial society, 15. Signature of church, 16. Signature of other, 17. Signature of, 18. Signature of, 19. Signature of, 20. Signature of, 21. Signature of, 22. Signature of, 23. Signature of, 24. Signature of, 25. Signature of, 26. Signature of, 27. Signature of, 28. Signature of, 29. Signature of, 30. Signature of, 31. Signature of, 32. Signature of, 33. Signature of, 34. Signature of, 35. Signature of, 36. Signature of, 37. Signature of, 38. Signature of, 39. Signature of, 40. Signature of, 41. Signature of, 42. Signature of, 43. Signature of, 44. Signature of, 45. Signature of, 46. Signature of, 47. Signature of, 48. Signature of, 49. Signature of, 50. Signature of, 51. Signature of, 52. Signature of, 53. Signature of, 54. Signature of, 55. Signature of, 56. Signature of, 57. Signature of, 58. Signature of, 59. Signature of, 60. Signature of, 61. Signature of, 62. Signature of, 63. Signature of, 64. Signature of, 65. Signature of, 66. Signature of, 67. Signature of, 68. Signature of, 69. Signature of, 70. Signature of, 71. Signature of, 72. Signature of, 73. Signature of, 74. Signature of, 75. Signature of, 76. Signature of, 77. Signature of, 78. Signature of, 79. Signature of, 80. Signature of, 81. Signature of, 82. Signature of, 83. Signature of, 84. Signature of, 85. Signature of, 86. Signature of, 87. Signature of, 88. Signature of, 89. Signature of, 90. Signature of, 91. Signature of, 92. Signature of, 93. Signature of, 94. Signature of, 95. Signature of, 96. Signature of, 97. Signature of, 98. Signature of, 99. Signature of, 100. Signature of.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1370

CERTIFICATE OF DEATH

01365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>S.</u> Last <u>BRADY</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL PARKER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH REES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Felix Brady Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Secondary Decemnia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>2-22-1958</u> that I last saw the deceased alive on <u>2-29-1958</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>169 N. Lee St. Cumberland, Md.</u> DATE SIGNED <u>2-28-58</u>							
ACTUAL SIGNATURE <u>[Signature]</u>		PHYSICIAN'S NAME (Type) <u>Byron Right</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Right</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-BALTIMORE-STATE DEPARTMENT OF HEALTH

BUREAU V. S.

FEB 26 1959

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1371

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Memorial Hospital		e. STREET ADDRESS 22 N. Waverly Terrace	
3. NAME OF DECEASED (Type or print) James Howard Brinkman		4. DATE OF DEATH Feb. 28 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12-1872
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Supt. of N.G. Taylor Tin Mill	
11. BIRTHPLACE (State or foreign country) Town Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Brinkman		14. MOTHER'S MAIDEN NAME Mary Slider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-4353	
17. INFORMANT (wife) Nina M. Brinkman, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 260 X DUE TO (b) Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH sudden ? about 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 28-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

Mary Slider

53 (wife) Nina M. Brinkman, Cumberland, Md.

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vascular disease
a Mellitus

BUREAU V. 2

MAR 3 1959

RECEIVED

421

5 Hill

CERTIFICATE OF DEATH

01367

Reg. Dist. No.

1372

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS GREEN SPRING 85X3	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LEE Last BROWN		4. DATE OF DEATH Month FEBRUARY Day 8 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 18, 1957
9. AGE (In years last birthday) 4 MOS.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES F. BROWN		14. MOTHER'S MAIDEN NAME MARGUERITE DEAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration & Cerebral Edema 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Upper Respiratory Infection (Long Standing) DUE TO (c) 1 week		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:45 A.M. , 19 58 , to 8:45 A.M. , 19 58 , that I last saw the deceased alive on 8:45 A.M. , 19 58 , and that death occurred at 6:23 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius D. Whitworth M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 10 Feb 58	
PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Forest Glenn		22d. LOCATION (City, town, or county) (State) Greenspring W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Rich. S. Dwyer		ADDRESS Romney W. Va.	
24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE W. V. Z.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

TIME

PLACE

BUREAU V. S.

FEB 13 1959

RECEIVED

1373 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Greene St.</u>		d. STREET ADDRESS <u>26 Greene St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALFRED</u> Last <u>IRYAN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1899</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi cab.</u>	
11. BIRTHPLACE (State or foreign country) <u>Saxton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred E. Bryan</u>		14. MOTHER'S MAIDEN NAME <u>Emma Leonard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-8783</u>	
17. INFORMANT <u>Mrs. Harry White, 26 Greene St., Cumberland, Md</u>		Address <u>Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid colon</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>generalized metastasis to</u> DUE TO (c) <u>liver, peritoneum</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/10/1957</u> to <u>2/10/1958</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>58</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl R. Paul</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>36 Greene St. Cumberland, Md. 2/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earl R. Paul M. D.</u>		<u>36 Green St. Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

FEB 13 1958

RECEIVED

BALTIMORE, 18

1374

CERTIFICATE OF DEATH

01369

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 11 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 425 Beall Street				d. STREET ADDRESS 425 Beall Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Caroline Middle Burke Last Burke				4. DATE OF DEATH Month February Day 16 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 27-1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper at home. At Home.		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edwin C. Pickett				14. MOTHER'S MAIDEN NAME Eunice Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lawrence A. Burke Address Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO Myocarditis (c) Myocarditis							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/17/54 , 19 54 , to 2/16/58 , 19 58 , that I last saw the deceased alive on 2/14/58 , 19 58 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Centre St.- Cumberland, Md. DATE SIGNED Feb 21 1958							
ACTUAL SIGNATURE Richard J. Williams M.D.							
PHYSICIAN'S NAME (Type) Richard J. Williams M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 19-58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE FEB 21 '58	
				24b. REGISTRAR'S SIGNATURE Ruth E. Silcox			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Date of Death	
John Doe		1952-01-15	
Age		Sex	
45		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
New York City		New York City	
Cause of Death		Immediate Cause	
Heart Disease		Myocardial Infarction	
Contributing Cause		Hypertension	
Manner of Death		Occupation	
Natural		Teacher	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Death	
1952-01-15		New York City	

BUREAU V. S.

FEB 21 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1373 Item 7 Film G226 3-7-58 et
1874
CERTIFICATE OF DEATH

01370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alle gany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>13 North Waverly Terrace</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Irene</u> <u>Burke</u>		4. DATE OF DEATH Month Day Year <u>February</u> <u>27</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 23, 1874</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gogley</u>		14. MOTHER'S MAIDEN NAME <u>Emma Gogley Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Pt.'s Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Uremic Poisoning</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wk.</u> <u>20 yr.</u> <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis—advanced age.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 11, 1958</u> to <u>February 27, 1958</u> , that I last saw the deceased alive on <u>February 27, 1958</u> , and that death occurred at <u>7:08 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Maryland.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>James J. Hallinan</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. J.P. Hallinan</u> <u>140 Bedford Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

1959 7 MAR

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
1376 CERTIFICATE OF DEATH					Reg. Dist. No. 01371						
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 4 HR. 5 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN 75x-3						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last BURKETT					4. DATE OF DEATH Month FEBRUARY Day 9 Year 1958						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 8, 1958		9. AGE (In years last birthday) yrs. 4 5 min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DELFORD S. BURKETT					14. MOTHER'S MAIDEN NAME ALVENIA B. WEAVERLY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.4 DUE TO Coxsack Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cataleptosis DUE TO Diaphragmatic Hernia & Situs Inversus (c) Diaphragmatic Hernia & Situs Inversus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE DR. L. MOULD					M.D.						
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-9-58		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital			22d. LOCATION (City, town, or county) (State) Cumberland Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md.					ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 10 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach		

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BUREAU V. S.

FEB 10 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1377 CERTIFICATE OF DEATH

01372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE, CITY	
f. STREET ADDRESS 1026 NATIONAL HIGHWAY		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAZEL Middle E. Last BURKETT		4. DATE OF DEATH Month FEB. Day 23 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE LOAR		14. MOTHER'S MAIDEN NAME LUELLA LOAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. PTS. CHART.	
17. INFORMANT PTS. CHART.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and DUE TO hypertension (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20/58 , 19 58 , to 2/23/58 , 19 58 , that I last saw the deceased alive on 2/23/58 , 19 58 , and that death occurred at 7:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) Cumberland, MD. DATE SIGNED 2/23/58 ACTUAL SIGNATURE R. J. Williams, M.D. PHYSICIAN'S NAME (Type) R. J. WILLIAMS, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-23-1958	22c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	22d. LOCATION (City, town, or county) (State) ECKHART, MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST, FROSTBURG, MD.		24. REC'D BY REGISTRAR FEB 26 58	
24b. REGISTRAR'S SIGNATURE W. Leach		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIANO STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

FEB 26 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1417

CERTIFICATE OF DEATH

Reg. Dist. 01373

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 8 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle DE SALES Last CHAMBERS		4. DATE OF DEATH Month FEBRUARY Day 11 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Chambers		14. MOTHER'S MAIDEN NAME Mary McAllister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-14-1456	
17. INFORMANT Mrs. Annie Chambers, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491x Congestive Heart failure DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 hrs. (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 9, 1958 , to Feb. 11, 1958 , that I last saw the deceased alive on Feb. 11, 1958 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED 2/11/58	
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-1958	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
		24b. REGISTRAR'S SIGNATURE Overman	

CERTIFICATE OF DEATH

1913

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED
FEB 13 1958
BUREAU V. S.

TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1378

CERTIFICATE OF DEATH

01374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loren</u> Middle <u>Howard</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/76</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Ann Parlett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213 24 5535</u>	
17. INFORMANT <u>Patient's Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Breast Calcifications with local collections</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15, 1958</u> to <u>2-17, 1958</u> , that I last saw the deceased alive on <u>2-17, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>16 Greene St. Cumberland Md 2-1858</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>J. T. Johnson</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>Dr. James T. Johnson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Seach</u>	

BUREAU V. 3.

FEB 24 1953

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1418

Item 9 Film G225 2-26-58 et

CERTIFICATE OF DEATH

01375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELSIE Middle MAE Last CLARK				4. DATE OF DEATH Month 2 Day 10 Year 1958.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Garrett County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard LaRue				14. MOTHER'S MAIDEN NAME Mary Alice Woods			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Beulah Reine, 1266 James St., Balto., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes - Diabetic Coma				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957 , 19____, to Feb 10, 1958 , that I last saw the deceased alive on Feb 10, 1958 , and that death occurred at 10:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE WOMC Lane M.D. Frostburg				DATE SIGNED Feb 12 1958			
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hefer Funeral Home ADDRESS E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR FEB 18 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

FEB 19 1934

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1379 CERTIFICATE OF DEATH

Reg. Dist. No.

01376

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 806 Elmwood Lane		e. STREET ADDRESS 806 Elmwood Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lulu Middle Edna Last Conover		4. DATE OF DEATH Month Feb. Day 3, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Coshocton, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward J. Kuntz		14. MOTHER'S MAIDEN NAME Nell Crawley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles W. Whetzel		Address 806 Elmwood Lane, Md. Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20/57 , 19____, to 2/3/58 , 19____, that I last saw the deceased alive on 2/3/58 , 19____, and that death occurred at 11:20 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 456 N. Centre St., DATE SIGNED 2/5/58	
ACTUAL SIGNATURE Leo H. Ley Jr. M.D.			
PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 10 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach	

CERTIFICATE OF DEATH

EX-114 BOMID

RECEIVED
FEB 10 1953
BUREAU V. S.

CERTIFICATE OF DEATH

01377

Reg. Dist. No.

1380

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Alleg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH First Middle Last JOHN SMITH CONRAD				4. DATE OF DEATH Month Day Year FEB. 1, 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 29, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Cumberland Brewery		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CHARLES W. CONRAD				14. MOTHER'S MAIDEN NAME MARGARET SMITH CONRAD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 714 N. Centre Street			
17. INFORMANT Mrs. Margaret Bone				Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-29 , 19 58 , to 2-1 , 19 58 , that I last saw the deceased alive on 1-31 , 19 58 , and that death occurred at 10:25 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland, Md. DATE SIGNED 3-1-58							
ACTUAL SIGNATURE William P. James M.D.							
PHYSICIAN'S NAME (Type) Doctor W.P. James, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 3, 1958		22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE FEB 5 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

FEB 5 1963

RECEIVED

RECEIVED

1381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>74</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Alice</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Kennells Mills, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Kennell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Lester Cook Rt. # 4 Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exacerbated arteriosclerosis heart</u> <u>420.0</u> DUE TO <u>chronic decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 17, 1958</u> to <u>June 17, 1958</u> , that I last saw the deceased alive on <u>June 17, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D. <u>43 Everett, Cumberland, Md. 4/1/58</u>				DATE SIGNED <u>4/1/58</u>			
PHYSICIAN'S NAME (Type) <u>Blane M. Schindler M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 21 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. R. Schindler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01379**

1432

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cumberland				c. LENGTH OF STAY IN 1b 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In auto at Dishong Atlantic Service Station-				f. STREET ADDRESS 519 Prince George St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Vernon Last Courtney				4. DATE OF DEATH Month Feb. Day 6 Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23-1919	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent-Prudential Insurance Co.				10b. KIND OF BUSINESS OR INDUSTRY Girard Ala.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Henry V. Courtney				14. MOTHER'S MAIDEN NAME Willie M. Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2 219-03-8497		17. INFORMANT Harold Ritter, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Coronary sclerosis with angina syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH sudden about 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 6-1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
HEALTH DEPT.

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. I.

FEB 11 1958

RECEIVED

1382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>56 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PATRICK</u> Middle <u>COYLE</u> Last <u>COYLE</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 27, 1873</u>	
9. AGE (In years lost birthday) yrs. <u>85</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor, Retired Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND, Westport County USA</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>THOMAS COYLE (DECEASED)</u>				14. MOTHER'S MAIDEN NAME <u>Bridget KEARNS (DECEASED)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-09-7939</u>			
17. INFORMANT <u>PT'S CHART</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Haemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pancreatitis</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>8 wks</u> <u>5 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1957</u> , to <u>Feb. 10, 1958</u> , that I last saw the deceased alive on <u>Feb. 9, 1958</u> , and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clay E. Durrett</u>				ADDRESS (Street, city or town, state) <u>236 Virginia Ave. Cumberland, Md.</u>			
DATE SIGNED <u>7/11/58</u>							
PHYSICIAN'S NAME (Type) <u>CLAY E. DURRETT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 13 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Decker</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 18

Form 100-1 (1-1-35)

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. DATE OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 2

FEB 12 1938

RECEIVED

1433
CERTIFICATE OF DEATH

01381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale, Md.				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shortest Day Road				/ d. STREET ADDRESS Shortest Day Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANGELINE C. DUFF				4. DATE OF DEATH Month Feb. Day 25 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lebanon Indiana	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME David W. Campbell				14. MOTHER'S MAIDEN NAME Amanda Harney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address James C. Duff La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Hypertension Cardio 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-11-1958 to 2-25-1958 that I last saw the deceased alive on 2-23-1958 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Williams M.D.				ADDRESS (Street, city or town, state) 1220 S. Centre St. Cumberland, Md.			
DATE SIGNED 2/26/58							
PHYSICIAN'S NAME (Type) W. H. Williams							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/1958		22c. NAME OF CEMETERY OR CREMATORY Venango Cemetery		22d. LOCATION (City, town, or county) (State) Venango, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAR 3 '58	
24b. REGISTRAR'S SIGNATURE Deborah							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 3

MAR 3 1958

RECEIVED

1383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/8/58			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 39 Mary Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Earsom		4. DATE OF DEATH Month February Day 18 , Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1874		
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Tin Mill		10b. KIND OF BUSINESS OR INDUSTRY Worker (Labor)			
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Foote		14. MOTHER'S MAIDEN NAME Mary Neff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9290			
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Senile Deterioration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/8/58 , 19 58 , to 2/18/58 , 19 58 , that I last saw the deceased alive on 2/18/58 , 19 58 , and that death occurred at 8:42 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 2/19/58			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-21-58			
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		22d. LOCATION (City, town, or county) (State) Fort Ashby W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '58			
24b. REGISTRAR'S SIGNATURE W. H. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM WOOD		DATE OF BIRTH 1880		PLACE OF BIRTH NEW YORK	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED		DATE OF MARRIAGE 1905	
PLACE OF DEATH BALTIMORE		DATE OF DEATH FEB 24 1958		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF INTERMENT CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN DR. J. H. WOOD		SIGNATURE OF DECEASED WILLIAM WOOD		SIGNATURE OF WITNESSES DR. J. H. WOOD	
DATE OF SIGNATURE FEB 24 1958		DATE OF SIGNATURE FEB 24 1958		DATE OF SIGNATURE FEB 24 1958	

BUREAU V. 3

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01383

Reg. Dist. No.

1384

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

02

Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O. A.1st.Aide Station, K-S.Tire Co.

d. STREET ADDRESS

609 Piedmont Ave.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First
Andrew

Middle
Jackson

Last
Everett

4. DATE
OF
DEATH

Month
Feb.

Day
4

Year
1958

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Feb. 11 1895

9. AGE (In years
last birthday)

62 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Steam tender-Kelly-Springfield T.Co.-Mineral Co.W.Va.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Everett

14. MOTHER'S MAIDEN NAME

Eliza Logsdon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes,

W. W. # 1

16. SOCIAL SECURITY NO.

214-07-0558

17. INFORMANT

Address

(wife) Mary Wood Everett, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardiac tamponade

INTERVAL BETWEEN
ONSET AND DEATH

sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b) rupture of a dissecting aneurism of aorta.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

19

20d. INJURY OCCURRED
While
at work ☐ Not while
of work ☐

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL
SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒

Feb. 4-1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2/7/58

22c. NAME OF CEMETERY OR CREMATORY

S. S. Peter & Paul's

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Charles L. George Cumberland, Maryland

24a. REC'D BY REGISTRAR

FEB 10 '58

24b. REGISTRAR'S SIGNATURE

[Signature]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1953

RECEIVED

CERTIFICATE OF DEATH

1419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hope Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>C. FAZENBAKER</u> Last <u></u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>22</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEV. 23, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonas Weitzell</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Sigler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Florence Fazenbaker, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arthritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days - years -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 54</u> to <u>Feb 22, 19 58</u> , that I last saw the deceased alive on <u>Feb 21, 19 58</u> and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>Broadway, Frostburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M. D.</u>		DATE SIGNED <u>Feb 26 '58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Garrett County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 26 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REGISTRATION

DECEASED

DATE

PLACE OF BIRTH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. 3

FEB 26 1958

RECEIVED

DR. WEISMAN

1385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 1/2 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle W Last FISHER				4. DATE OF DEATH Month FEBRUARY Day 6 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 20, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) PENNA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN T. FISHER				14. MOTHER'S MAIDEN NAME NANCY GROWDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217 10 7844		17. INFORMANT Mrs. Betty Fisher		Address Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Posterolateral Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cardiovascular Disease DUE TO 1958 (c) Blaucoma DUE TO Sept 1957 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blaucoma (b) Sept 1957 INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 6, 1958 , to Feb 6, 1958 , that I last saw the deceased alive on Feb 6, 1958 , and that death occurred at 10:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 2/6/58							
ACTUAL SIGNATURE S. G. WEISMAN M.D.				PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D., Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1958		22c. NAME OF CEMETERY OR CREMATORY Centerary Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
24b. REGISTRAR'S SIGNATURE W. B. Smith							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME OF DECEASED		AGE		SEX		RACE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY AND STATE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF BIRTH		DATE OF BIRTH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

FEB 11 1959

RECEIVED

CERTIFICATE OF DEATH

01386

Reg. Dist. No.

1386

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN TB 78 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Flurshutz		4. DATE OF DEATH Month Feb. Day 15, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Store Prop.		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME H. U. F. Flurshutz		14. MOTHER'S MAIDEN NAME Margaret S. Bachman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Arthur H. Flurshutz		Address Cumberland, Md. 856 Gephart Drive,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Pulmonary Hypostasis DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2nd 1958 to Feb. 15th 1958 , that I last saw the deceased alive on Feb. 15th 1958 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED Feb. 17, 1958	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/58	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR FEB 20 '58		24b. REGISTRAR'S SIGNATURE Albert Smith	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

BUREAU V. 3

FEB 20 1923

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. JOHNSON		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		1387 CERTIFICATE OF DEATH		Reg. Dist. No. 01387	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 176 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ALGONQUIN HOTEL-CUMB. & BALT. STS.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle GOEBEL Last GOEBEL				4. DATE OF DEATH Month FEBRUARY Day 25 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 23	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Music Teacher		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY GOEBEL				14. MOTHER'S MAIDEN NAME CHRISTINE GERLACH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-01-9379		17. INFORMANT Richard Hamill Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO (b) 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 157X DUE TO (c) 157X INTERVAL BETWEEN ONSET AND DEATH 7 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrolysis of Gall Bladder with cholelithiasis and cholecystitis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30, 1957 to February 25, 1958 that I last saw the deceased alive on January 24, 1958 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. J. Johnson Jr.				ADDRESS (Street, city or town, state) 169 Grove St. Cumberland Md 21226-58			
PHYSICIAN'S NAME (Type) DR. JAMES T. JOHNSON				DATE SIGNED MAR 3 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 27- 58		22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland, Maryland			
24a. REC'D BY REGISTRAR MAR 3 '58				24b. REGISTRAR'S SIGNATURE W. J. Johnson			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: JAMES EARL JOHNSON
2. SEX: MALE
3. AGE: 34
4. DATE OF BIRTH: NOV. 23, 1924
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESSES: [illegible]
12. SIGNATURE OF MINISTER: [illegible]
13. SIGNATURE OF CLERK: [illegible]

BUREAU V. 3

MAR 3 1958

RECEIVED

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1388

CERTIFICATE OF DEATH

Reg. Dist. No. 01388

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
c. LENGTH OF STAY IN b. 12/28/57		d. STREET ADDRESS 109 S. Lee Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Ann Last Gough		4. DATE OF DEATH Month February Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1885
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Paw Paw, West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Ryan		14. MOTHER'S MAIDEN NAME Sarah Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/28/57 , 19____, to 2/23/58 , 19____, that I last saw the deceased alive on 2/22/58 , 19____, and that death occurred on _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 2/24/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/58	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 12/26/58		24b. REGISTRAR'S SIGNATURE W. J. McLean	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1389

CERTIFICATE OF DEATH

01389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>C.</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/98</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Kemp</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PT. Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombophlebitis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Degeneration</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/30</u> , 19 <u>58</u> , to <u>7/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>456 N Center Street</u> DATE SIGNED <u>7/8/58</u>							
ACTUAL SIGNATURE <u>Leo J. Ley Jr.</u>		M.D. _____					
PHYSICIAN'S NAME (Type) <u>Dr. Leo H. Ley</u>		_____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Pauls Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INVESTIGATING STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

FEB 11 1953

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01390

Reg. Dist. No.

1390

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland, Md.</u>		LENGTH OF STAY (in this place) <u>35 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>38 Grand Ave. Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Grand Ave. Cumberland, Md.</u>				STREET ADDRESS (If rural give location) <u>38 Grand Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Bessie Eleanore Guthridge</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 22, 19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 30, 1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Oldtown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Haugh</u>				14. MOTHER'S MAIDEN NAME <u>Lydia E. Piper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Alva H. Duckworth, Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
430.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)				<u>Coronary Thrombosis</u> <u>Hypertensive Art. Scl. CVD</u>		<u>1 hr</u> <u>5 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/7/58</u> , 19 <u>58</u> , to <u>2/22/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/21/58</u> , 19 <u>58</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>2/24/58</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-25-58</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>			
DATE <u>FEB 27 '58</u>							

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1391

CERTIFICATE OF DEATH

01391

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>410 Louisiana Ave</u>				d. STREET ADDRESS <u>410 Louisiana Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Heberle</u> Last <u>Heberle</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Retired Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celunose Corp. Fla.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-7370</u>		17. INFORMANT <u>Mr. Amanda Heberle</u> Address <u>Cumb. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostate</u> DUE TO (b) <u>Carcinomatous</u> DUE TO (c) <u>Uroemia</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Feb. 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 11</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton J. Lurett</u> M.D.		ADDRESS (Street, city or town, state) <u>236 W. 1st. Cumberland</u>		DATE SIGNED <u>7/5/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumb. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumb. Md</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased <i>John M. Smith</i>		Date of Death <i>11/15/50</i>	
Age <i>45</i>		Sex <i>Male</i>	
Race <i>White</i>		Marital Status <i>Married</i>	
Occupation <i>Engineer</i>		Cause of Death <i>Heart Disease</i>	
Place of Birth <i>USA</i>		Date of Birth <i>11/15/05</i>	
Residence <i>250 N. 15th St. Baltimore, Md.</i>		Physician <i>Dr. J. M. Smith</i>	
Hospital <i>St. Mary's Hospital</i>		Manner of Death <i>Natural</i>	
Underlying Cause <i>Coronary Artery Disease</i>		Immediate Cause <i>Myocardial Infarction</i>	
Contributing Cause <i>Hypertension</i>		Other Cause <i>None</i>	
Date of Autopsy <i>11/20/50</i>		Autopsy <i>Yes</i>	
Signature of Physician <i>Dr. J. M. Smith</i>		Signature of Registrar <i>John M. Smith</i>	

BUREAU V. 2

FEB 10 1951

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1420 CERTIFICATE OF DEATH

01392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vale Summit			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last HIGGINS				4. DATE OF DEATH Month 2 Day 14 Year 1958.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb.	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubberworker				10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Vale Summit		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Michael Higgins				14. MOTHER'S MAIDEN NAME Mary Ann Delaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss June Higgins, R.D.#1, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Coronary insufficiency				INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 13, 1958 , to Feb 14, 1958 , that I last saw the deceased alive on Feb 13, 1958 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE WOM Lane M.D.				ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Feb 14 1958			
PHYSICIAN'S NAME (Type) WOM Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/58		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Winters				ADDRESS Hafer Funeral Home		24a. REC'D BY REGISTRAR Feb 24 '58	
				24b. REGISTRAR'S SIGNATURE Alber...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

01308

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF JAILER</p>	
<p>21. SIGNATURE OF WARDEN</p>		<p>22. SIGNATURE OF CHIEF OF POLICE</p>		<p>23. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>24. SIGNATURE OF COUNTY CLERK</p>	
<p>25. SIGNATURE OF CITY CLERK</p>		<p>26. SIGNATURE OF TOWN CLERK</p>		<p>27. SIGNATURE OF VILLAGE CLERK</p>		<p>28. SIGNATURE OF POST OFFICE CLERK</p>	
<p>29. SIGNATURE OF SCHOOL CLERK</p>		<p>30. SIGNATURE OF CHURCH CLERK</p>		<p>31. SIGNATURE OF SYNAGOGUE CLERK</p>		<p>32. SIGNATURE OF MOSQUE CLERK</p>	
<p>33. SIGNATURE OF TEMPLE CLERK</p>		<p>34. SIGNATURE OF CHAPLAIN</p>		<p>35. SIGNATURE OF MINISTER</p>		<p>36. SIGNATURE OF PASTOR</p>	
<p>37. SIGNATURE OF RABBI</p>		<p>38. SIGNATURE OF PRIEST</p>		<p>39. SIGNATURE OF BISHOP</p>		<p>40. SIGNATURE OF ARCHBISHOP</p>	
<p>41. SIGNATURE OF CARDINAL</p>		<p>42. SIGNATURE OF DEACON</p>		<p>43. SIGNATURE OF MONK</p>		<p>44. SIGNATURE OF NUN</p>	
<p>45. SIGNATURE OF PRIOR</p>		<p>46. SIGNATURE OF ABBOT</p>		<p>47. SIGNATURE OF SUPERIOR</p>		<p>48. SIGNATURE OF CONVENT</p>	
<p>49. SIGNATURE OF MONASTERY</p>		<p>50. SIGNATURE OF HERMITAGE</p>		<p>51. SIGNATURE OF RETIRE</p>		<p>52. SIGNATURE OF CLOISTER</p>	
<p>53. SIGNATURE OF CHAMBERLAIN</p>		<p>54. SIGNATURE OF VALET</p>		<p>55. SIGNATURE OF Usher</p>		<p>56. SIGNATURE OF ALMOND</p>	
<p>57. SIGNATURE OF BUTLER</p>		<p>58. SIGNATURE OF COOK</p>		<p>59. SIGNATURE OF BAKER</p>		<p>60. SIGNATURE OF MILLER</p>	
<p>61. SIGNATURE OF TANNER</p>		<p>62. SIGNATURE OF SADDLER</p>		<p>63. SIGNATURE OF SHOE MAKER</p>		<p>64. SIGNATURE OF HAT MAKER</p>	
<p>65. SIGNATURE OF JEWELLER</p>		<p>66. SIGNATURE OF OPTICIAN</p>		<p>67. SIGNATURE OF BARBER</p>		<p>68. SIGNATURE OF DRESSMAKER</p>	
<p>69. SIGNATURE OF TAILOR</p>		<p>70. SIGNATURE OF HATTER</p>		<p>71. SIGNATURE OF MILLINER</p>		<p>72. SIGNATURE OF BOOKBINDER</p>	
<p>73. SIGNATURE OF WRITER</p>		<p>74. SIGNATURE OF COMPOSER</p>		<p>75. SIGNATURE OF PRINTER</p>		<p>76. SIGNATURE OF PUBLISHER</p>	
<p>77. SIGNATURE OF EDITOR</p>		<p>78. SIGNATURE OF MANAGER</p>		<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF ASSISTANT</p>	
<p>81. SIGNATURE OF SUPERVISOR</p>		<p>82. SIGNATURE OF INSPECTOR</p>		<p>83. SIGNATURE OF AGENT</p>		<p>84. SIGNATURE OF SALESMAN</p>	
<p>85. SIGNATURE OF BUYER</p>		<p>86. SIGNATURE OF STOCKER</p>		<p>87. SIGNATURE OF PACKER</p>		<p>88. SIGNATURE OF SHIPPER</p>	
<p>89. SIGNATURE OF CARRIER</p>		<p>90. SIGNATURE OF DRIVER</p>		<p>91. SIGNATURE OF CONDUCTOR</p>		<p>92. SIGNATURE OF ENGINEER</p>	
<p>93. SIGNATURE OF FIREMAN</p>		<p>94. SIGNATURE OF PORTER</p>		<p>95. SIGNATURE OF JANITOR</p>		<p>96. SIGNATURE OF CLEANER</p>	
<p>97. SIGNATURE OF PAINTER</p>		<p>98. SIGNATURE OF CARPENTER</p>		<p>99. SIGNATURE OF MASON</p>		<p>100. SIGNATURE OF PLUMBER</p>	
<p>101. SIGNATURE OF ELECTRICIAN</p>		<p>102. SIGNATURE OF MECHANIC</p>		<p>103. SIGNATURE OF TUNER</p>		<p>104. SIGNATURE OF REPAIRER</p>	
<p>105. SIGNATURE OF COOK</p>		<p>106. SIGNATURE OF BUTLER</p>		<p>107. SIGNATURE OF VALET</p>		<p>108. SIGNATURE OF Usher</p>	
<p>109. SIGNATURE OF ALMOND</p>		<p>110. SIGNATURE OF BAKER</p>		<p>111. SIGNATURE OF MILLER</p>		<p>112. SIGNATURE OF TANNER</p>	
<p>113. SIGNATURE OF SADDLER</p>		<p>114. SIGNATURE OF SHOE MAKER</p>		<p>115. SIGNATURE OF HAT MAKER</p>		<p>116. SIGNATURE OF JEWELLER</p>	
<p>117. SIGNATURE OF OPTICIAN</p>		<p>118. SIGNATURE OF BARBER</p>		<p>119. SIGNATURE OF DRESSMAKER</p>		<p>120. SIGNATURE OF TAILOR</p>	
<p>121. SIGNATURE OF HATTER</p>		<p>122. SIGNATURE OF MILLINER</p>		<p>123. SIGNATURE OF BOOKBINDER</p>		<p>124. SIGNATURE OF WRITER</p>	
<p>125. SIGNATURE OF COMPOSER</p>		<p>126. SIGNATURE OF PRINTER</p>		<p>127. SIGNATURE OF PUBLISHER</p>		<p>128. SIGNATURE OF EDITOR</p>	
<p>129. SIGNATURE OF MANAGER</p>		<p>130. SIGNATURE OF CLERK</p>		<p>131. SIGNATURE OF ASSISTANT</p>		<p>132. SIGNATURE OF SUPERVISOR</p>	
<p>133. SIGNATURE OF INSPECTOR</p>		<p>134. SIGNATURE OF AGENT</p>		<p>135. SIGNATURE OF SALESMAN</p>		<p>136. SIGNATURE OF BUYER</p>	
<p>137. SIGNATURE OF STOCKER</p>		<p>138. SIGNATURE OF PACKER</p>		<p>139. SIGNATURE OF SHIPPER</p>		<p>140. SIGNATURE OF CARRIER</p>	
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<p>145. SIGNATURE OF PORTER</p>		<p>146. SIGNATURE OF JANITOR</p>		<p>147. SIGNATURE OF CLEANER</p>		<p>148. SIGNATURE OF PAINTER</p>	
<p>149. SIGNATURE OF CARPENTER</p>		<p>150. SIGNATURE OF MASON</p>		<p>151. SIGNATURE OF PLUMBER</p>		<p>152. SIGNATURE OF ELECTRICIAN</p>	
<p>153. SIGNATURE OF MECHANIC</p>		<p>154. SIGNATURE OF TUNER</p>		<p>155. SIGNATURE OF REPAIRER</p>		<p>156. SIGNATURE OF COOK</p>	
<p>157. SIGNATURE OF BUTLER</p>		<p>158. SIGNATURE OF VALET</p>		<p>159. SIGNATURE OF Usher</p>		<p>160. SIGNATURE OF ALMOND</p>	
<p>161. SIGNATURE OF BAKER</p>		<p>162. SIGNATURE OF MILLER</p>		<p>163. SIGNATURE OF TANNER</p>		<p>164. SIGNATURE OF SADDLER</p>	
<p>165. SIGNATURE OF SHOE MAKER</p>		<p>166. SIGNATURE OF HAT MAKER</p>		<p>167. SIGNATURE OF JEWELLER</p>		<p>168. SIGNATURE OF OPTICIAN</p>	
<p>169. SIGNATURE OF BARBER</p>		<p>170. SIGNATURE OF DRESSMAKER</p>		<p>171. SIGNATURE OF TAILOR</p>		<p>172. SIGNATURE OF HATTER</p>	
<p>173. SIGNATURE OF MILLINER</p>		<p>174. SIGNATURE OF BOOKBINDER</p>		<p>175. SIGNATURE OF WRITER</p>		<p>176. SIGNATURE OF COMPOSER</p>	
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<p>201. SIGNATURE OF MASON</p>		<p>202. SIGNATURE OF PLUMBER</p>		<p>203. SIGNATURE OF ELECTRICIAN</p>		<p>204. SIGNATURE OF MECHANIC</p>	
<p>205. SIGNATURE OF TUNER</p>		<p>206. SIGNATURE OF REPAIRER</p>		<p>207. SIGNATURE OF COOK</p>		<p>208. SIGNATURE OF BUTLER</p>	
<p>209. SIGNATURE OF VALET</p>		<p>210. SIGNATURE OF Usher</p>		<p>211. SIGNATURE OF ALMOND</p>		<p>212. SIGNATURE OF BAKER</p>	
<p>213. SIGNATURE OF MILLER</p>		<p>214. SIGNATURE OF TANNER</p>		<p>215. SIGNATURE OF SADDLER</p>		<p>216. SIGNATURE OF SHOE MAKER</p>	
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<p>253. SIGNATURE OF PLUMBER</p>		<p>254. SIGNATURE OF ELECTRICIAN</p>		<p>255. SIGNATURE OF MECHANIC</p>		<p>256. SIGNATURE OF TUNER</p>	
<p>257. SIGNATURE OF REPAIRER</p>		<p>258. SIGNATURE OF COOK</p>		<p>259. SIGNATURE OF BUTLER</p>		<p>260. SIGNATURE OF VALET</p>	
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<p>445. SIGNATURE OF SHIPPER</p>		<p>446. SIGNATURE OF CARRIER</p>		<p>447. SIGNATURE OF DRIVER</p>		<p>448. SIGNATURE OF CONDUCTOR</p>	
<p>449. SIGNATURE OF ENGINEER</p>		<p>450. SIGN</p>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

CERTIFICATE OF DEATH

01393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 24 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EARL Middle ROBERT Last HILL				4. DATE OF DEATH Month February Day 26 Year 19 58											
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 14, 1893		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired textile Emp				10b. KIND OF BUSINESS OR INDUSTRY Celanese				11. BIRTHPLACE (State or foreign country) MARYLAND, Borden Mines				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ROBERT M. HILL						14. MOTHER'S MAIDEN NAME ANNIE EISEL									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1				16. SOCIAL SECURITY NO. 217-10-7990		17. INFORMANT Mrs. Myrtle Hill, Cresaptown, Md. Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X cerebral stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterial hypertension DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-4 , 19 56 , to 2-26 , 19 58 , that I last saw the deceased alive on 2-26 , 19 58 , and that death occurred at 4:11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene Street DATE SIGNED 2-27-58 ACTUAL SIGNATURE L. Briggs M.D. 57 Greene Street PHYSICIAN'S NAME (Type) Dr. L. Briggs 57 Greene Street															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/1/58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park				22d. LOCATION (City, town, or county) (State) Frostburg, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md. ADDRESS						24a. REC'D BY REGISTRAR DATE MAR 4 '58		24b. REGISTRAR'S SIGNATURE Aw. L. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAR 4 1958

RECEIVED

1393

CERTIFICATE OF DEATH

01394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>218 Schley Street</u>		d. STREET ADDRESS <u>218 Schley Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Hirsch</u> Last <u>Hirsch</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1865</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wool + Hides + Bank</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Hirsch</u>		14. MOTHER'S MAIDEN NAME <u>Berenetta Lowenstein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Hirsch</u>		Address <u>Cumb Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> 420.1 DUE TO <u>Myocardial Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Coronary Arteriosclerosis</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mo. 3 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Left Ventricular Failure</u> November 17, 1957			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 17</u> , 19 <u>57</u> , to <u>February 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 8</u> , 19 <u>58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Samuel M. Jacobson</u> M.D.		50 Pershing Street	
PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M.D.</u>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East View Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumb Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1394

CERTIFICATE OF DEATH

01395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OHIO b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEVELAND 72x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS Past 8 Month 2915 CHOTHAM AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LEO SHANNON IMES				4. DATE OF DEATH Month Day Year FEB. 4 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 18, 1911	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED VETERAN				10b. KIND OF BUSINESS OR INDUSTRY Dye House Textile		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME <i>Proven to separation pay.</i> SHANNON IMES				14. MOTHER'S MAIDEN NAME JULIA SHREVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WORLD WAR II 217-10-8164		17. INFORMANT 230 Cecelia St Address BROTHER Charles W. Imes Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 2-4 , 19 58 , to 2-4 , 19 58 , that I last saw the deceased alive on 2-4 , 19 58 , and that death occurred at 1:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 62 Greene St. 2-4-58							
ACTUAL SIGNATURE James F. Scarpelli				M.D. 62 Greene St.			
PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.				62 GREENE ST., CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 6 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	

1395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CIMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CIMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>A.</u> Last <u>JACKSON</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 6, 1874</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>18</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - MAJESTIC BOWLING ALLEY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>SAMUEL JACKSON</u>			
14. MOTHER'S MAIDEN NAME <u>SARAH CAVANAUGH</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>215-10-4438A</u>			
16. SOCIAL SECURITY NO. <u>215-10-4438A</u>				17. INFORMANT <u>PATIENT'S CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction and Stroke</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 weeks</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, bilateral</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>December 1-11, 1958</u> , to <u>2-7-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 7, 1958</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Maryland.</u> DATE SIGNED <u>Wyand F. Doerner, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>FEB. 10 '58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS C EMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>FROSTBURG, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. DURST,</u>				ADDRESS <u>FROSTBURG, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. F. Doerner, Jr.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
FEB 11 1939
BUREAU V. 31

1434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian	
		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last JONES		4. DATE OF DEATH Month FEBRUARY Day 6 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner		10b. KIND OF BUSINESS OR INDUSTRY coal mines	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME Maragaret Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-05-7652	
17. INFORMANT Address Mrs. Mary W. Jones, Midlothian, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertensive Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH YEAR 5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 , 19 57 , to 2/6 , 19 58 , that I last saw the deceased alive on 2/4 , 19 58 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Devers		ADDRESS (Street, city or town, state) 134 E. Main St.,	
PHYSICIAN'S NAME (Type) John C. Devers, M. D.		DATE SIGNED 2/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-1958	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE FEB 10 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BATHING 18

BUREAU V. S.

FEB 10 1963

RECEIVED

1421 CERTIFICATE OF DEATH

01398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 308 Front		d. STREET ADDRESS 308 Front	
3. NAME OF DECEASED (Type or print) First Charles Middle Fisher Last Kalbaugh		4. DATE OF DEATH Month Feb. Day 13 Year 1958.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1867
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B & O.R.R.	11. BIRTHPLACE (State or foreign country) Westernport, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John D. Kalbaugh	
14. MOTHER'S MAIDEN NAME Mary Susan Simmons		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Earl Kalbaugh-Piedmont, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 Chronic Myocarditis and Myocardial Degeneration Not specified As Rheumatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Piedmont, W. Va.	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Feb 9, 1958 , to Feb. 13, 1958 , that I last saw the deceased alive on Feb. 12, 1958 , and that death occurred at 10:00 AM , from the causes and on the date stated above.	
22. ADDRESS (Street, city or town, state) Piedmont, W. Va.		23. DATE SIGNED Feb. 14 1958	
ACTUAL SIGNATURE Paul R. Wilson		PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 2/16/58	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl Boral		24a. REC'D BY REGISTRAR FEB 20 58	
ADDRESS Westernport, Md.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		40		M		W		1898		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1920		BALTIMORE, MD		JANE HARRIS		1938		BALTIMORE, MD	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1938		BALTIMORE, MD		BALTIMORE, MD		1938		BALTIMORE, MD	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1938		BALTIMORE, MD		DR. J. H. HARRIS		1938		BALTIMORE, MD	
MANNER OF DEATH		DATE		PLACE		NAME OF CORoner		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1938		BALTIMORE, MD		DR. J. H. HARRIS		1938		BALTIMORE, MD	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1938		BALTIMORE, MD		JANE HARRIS		1938		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF CORoner		DATE OF DEATH		PLACE OF DEATH	
DR. J. H. HARRIS		1938		BALTIMORE, MD		DR. J. H. HARRIS		1938		BALTIMORE, MD	
SIGNATURE OF CORoner		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
DR. J. H. HARRIS		1938		BALTIMORE, MD		JANE HARRIS		1938		BALTIMORE, MD	

BUREAU V. 8

FEB 20 1938

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS DEEMED TO HAVE BEEN DECEASED. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE DEATH OF ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE DEATH OF ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1396

CERTIFICATE OF DEATH

Reg. Dist. No.

01399

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSS Middle G arland Last KELLER				4. DATE OF DEATH Month FEBRUARY Day 16 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 26/1909	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Southern Hotel		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM KELLER				14. MOTHER'S MAIDEN NAME MARGARET DORSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9174		17. INFORMANT MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.1 DUE TO Ruptured esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver (Laennec's) DUE TO Hematemesis (c) Delirium tremens PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 10 " ? ? 10 days 8 "							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Fe. 6 , 19 58 , to Feb. 16 , 19 58 , that I last saw the deceased alive on Feb. 15 , 19 58 , and that death occurred at 10:15AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Md. DATE SIGNED 2/17/58							
ACTUAL SIGNATURE Samuel M. Jacobson, M.D. Cumberland, Maryland							
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR FEB 20 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

ALLEGANY

WAYNE

10 DAYS

10 DAYS

125 N. BOWEN STREET

MEMORIAL HOSPITAL

12

12

12

12

12

12

12

12

12

12

12

BUREAU V. S.

FEB 20 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01400

Reg. Dist. No.

1422

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 33 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 154 River Road				d. STREET ADDRESS 154 River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Estel Last Kenny				4. DATE OF DEATH Month Feb. Day 10 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23-1897		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant- Grocery & Meats		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Kenny				14. MOTHER'S MAIDEN NAME Mary V. Brophy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.1		16. SOCIAL SECURITY NO. 214-32-3134		17. INFORMANT Address (wife) Anna G.M. Kenny, Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 10-1958			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb 13/58		St. Peters Cemetery		Westernport, Md	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Fredlock Jr. Piedmont, W.Va				24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE W.H. Fredlock	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

FEB 13 1968

RECEIVED

1397

CERTIFICATE OF DEATH

01401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN TB <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				/d. STREET ADDRESS <u>901 Glenwood Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>F</u> Last <u>Ketterman</u>				4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Felix Swick</u>				14. MOTHER'S MAIDEN NAME <u>Ida Swick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Patient's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>August 19, 1957</u> to <u>2-27-1958</u> , that I last saw the deceased alive on <u>2-26</u> , 1958, and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>16 Greene St Cumberland Md</u>				DATE SIGNED <u>Mar 27 1958</u>			
ACTUAL SIGNATURE <u>Dr. J. T. Johnson</u>				M.D. <u>16 Greene St Cumberland Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. T. Johnson</u>				<u>16 Greene Street</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumb. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1895

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 3 1953

RECEIVED

3/11/58
James M. Mc
James M. Mc
James M. Mc

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1398

CERTIFICATE OF DEATH

01402

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VIRGINIA b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle B. Last LAHMAN		4. DATE OF DEATH Month FEB. Day 8, Year 19 58.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 27, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher - housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PETERSBURG, W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JAMES BAKER	
14. MOTHER'S MAIDEN NAME MARY S. DELAY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 232-62-5898		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, antero-lateral, extensive DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) eternis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Feb. , 19 58 , to 8 Feb. , 19 58 , that I last saw the deceased alive on 8 Feb. , 19 58 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 122 5 Center St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		DATE SIGNED 8 Feb. 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORY Lahmansville		22d. LOCATION (City, town, or county) (State) Lahmansville, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Walter S. Arnold		ADDRESS Petersburg, W. Va.	
24a. REC'D BY REGISTRAR FEB 18 58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 18 1958

BUREAU V. 21

CERTIFICATE OF DEATH

W. VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING ONE 18

1 1399 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01403

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2, Williams Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Elizabeth Laing		4. DATE OF DEATH Month Day Year Feb. 9 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1860
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Justin Grabenstein	
14. MOTHER'S MAIDEN NAME Margaret Mundy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT George E. Laing, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thaemia 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 wks 4 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 10, 1957 to Feb. 9, 1958 , that I last saw the deceased alive on Feb. 9, 1958 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clayton J. Jurett M.D.		ADDRESS (Street, city or town, state) 236 Ch. Lee Rd DATE SIGNED 2/10/58	
PHYSICIAN'S NAME (Type) Burial		22b. DATE THEREOF 2-12-1958	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

100-100000

FBI WASH DC

BUREAU V. 8

FEB 11 1958

RECEIVED

1423 CERTIFICATE OF DEATH

01404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Castle Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CATHERINE Middle LOGSDON Last		4. DATE OF DEATH Month 2/3/1958 Day 19 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 17th, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Germany, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isreal Duckworth		14. MOTHER'S MAIDEN NAME Mary Wiland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Elmer Ravenscroft		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 min. many years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 21, 1956 , to Feb 3, 1958 , that I last saw the deceased alive on Feb 2, 1958 , and that death occurred at 9 am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST DATE SIGNED Feb 3, 1958			
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D. M.D.		PHYSICIAN'S NAME (Type) LESKIE R. MILES JR. LONA CONING MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		24a. REC'D BY REGISTRAR FEB 6 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933 CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1888		PLACE OF BIRTH Maryland	
MARRIAGE Married		EDUCATION High School		OCCUPATION Carpenter		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH 1933		PLACE OF DEATH Home		RESIDENT Yes		DECEASED'S RESIDENCE 1234 Main St, Baltimore, Md.		DECEASED'S OCCUPATION Carpenter		DECEASED'S RELIGION Roman Catholic	
DECEASED'S NAME JAMES M. HARRIS		DECEASED'S AGE 45		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S DATE OF BIRTH 1888		DECEASED'S PLACE OF BIRTH Maryland	
DECEASED'S MARRIAGE Married		DECEASED'S EDUCATION High School		DECEASED'S OCCUPATION Carpenter		DECEASED'S RELIGION Roman Catholic		DECEASED'S MANNER OF DEATH Natural		DECEASED'S CAUSE OF DEATH Heart Disease	

BUREAU V. 31

FEB 6 1933

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01405

Reg. Dist. No.

1424

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Westernport		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Westernport			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church St				STREET ADDRESS (If rural give location) Church St.			
3. NAME OF DECEASED (Type or Print) Joseph L Mansfield				4. DATE OF DEATH (Month) (Day) (Year) Feb 19 19 58			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 3, 1877	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY News Stand		11. BIRTHPLACE (State or foreign country) Westernport Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME W.F. Mansfield				14. MOTHER'S MAIDEN NAME Mary Carney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Nora Mansfield, Westernport Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary Embolus						INTERVAL BETWEEN ONSET AND DEATH 11 Hours	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) None			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 19, 1958, to Feb. 19, 1958, that I last saw the deceased alive on Feb. 19, 1958, and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
SIGNATURE Paul B. Wilson		M.D.		ADDRESS (Street, city, town, state) Piedmont, W. Va.		DATE SIGNED Feb. 21, 1958	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Feb. 22/58		NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		LOCATION (City, town, or county) (State) Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE W. H. ...		25. FUNERAL DIRECTOR'S SIGNATURE W. H. ...		ADDRESS Piedmont W. Va.	
DATE FEB 24 '58							

CERTIFICATE OF DEATH

1. NAME OF DECEASED Joseph		2. SEX Male		3. RACE White	
4. DATE OF BIRTH July 1, 1892		5. DATE OF DEATH Feb. 24, 1958		6. PLACE OF BIRTH New York	
7. PLACE OF DEATH New York		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF JUDGE	

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

2. The information on this form is used for the purpose of determining the cause of death and for the purpose of recording the death. It is also used for the purpose of determining the age and sex of the deceased and for the purpose of determining the place of birth and the place of death.

3. The information on this form is also used for the purpose of determining the manner of death and for the purpose of determining the date of death. It is also used for the purpose of determining the date of birth and the date of death.

4. The information on this form is also used for the purpose of determining the cause of death and for the purpose of determining the manner of death. It is also used for the purpose of determining the date of death and the date of birth.

5. The information on this form is also used for the purpose of determining the cause of death and for the purpose of determining the manner of death. It is also used for the purpose of determining the date of death and the date of birth.

RECEIVED
FEB 24 1958
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01406

1400

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 209 Cecelia St.	
3. NAME OF DECEASED (Type or print) Evelyn First Marteny Middle Lost			4. DATE OF DEATH Month Feb. Day 11 Year 19 58		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4-1913		9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Morgantown, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Earl Pixler			14. MOTHER'S MAIDEN NAME Edith Hussing		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address (husband) Clemeth J. Marteny, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (left) (a), stating the underlying cause last, DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH a few hrs ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Feb. 11-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery	
				22d. LOCATION (City, town, or county) (State) Morgantown, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE FEB 13 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.	

RECEIVED

FEB 13 1953

BUREAU V. 2

FOR STATE
HEALTH DEPT.



Reg. Dist. No. **01407**

1401

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

MAR 3 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1435

CERTIFICATE OF DEATH

Reg. Dist. No.

01408

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last McCabe		4. DATE OF DEATH Month February Day 17 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Martin		14. MOTHER'S MAIDEN NAME Catherine Barry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. none	
17. INFORMANT Angela McCabe		Address Nikep, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Renal Disease, 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetese Millitis. 260x _____ 8yrs		INTERVAL BETWEEN ONSET AND DEATH 6mo 5yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 14, 1958 , to Feb 17, 1958 , that I last saw the deceased alive on Feb 14, 1958 , and that death occurred at 3:30am from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont W Va. DATE SIGNED _____ ACTUAL SIGNATURE James H Wolverson Sr M.D. _____ PHYSICIAN'S NAME (Type) James H Wolverson Sr Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/58	
22c. NAME OF CEMETERY OR CREMATORY St Gabriels Cemetery		22d. LOCATION (City, town, or county) (State) Barton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE FEB 20 '58		24b. REGISTRAR'S SIGNATURE W. H. Edmich	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the register, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01409

Reg. Dist. No.

1436

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinto (in auto)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinto Rt. 5, Cumberland, Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt.#5 Cumberland, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Conward Middle Maurice Last Miller		4. DATE OF DEATH Month Feb. Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14-1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber-		10b. KIND OF BUSINESS OR INDUSTRY Walter Yoder & Son	
11. BIRTHPLACE (State or foreign country) Jerome, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Smith		14. MOTHER'S MAIDEN NAME Ethel Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11		16. SOCIAL SECURITY NO. 220-40165	
17. INFORMANT (wife) Thelma Miller, Pinto, Md. Rt.#5		Address Cumberland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330 x DUE TO (b) Ruptured cerebral aneurism also had Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Coronary osteal sclerosis (right.)		INTERVAL BETWEEN ONSET AND DEATH A few hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 7-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR FEB 11 58	
		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81
BUREAU V. 81

1958

FEB 11 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1425

CERTIFICATE OF DEATH

Reg. Dist. No. 01410

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 14 W. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANDREW Middle FRANCIS Last MORRIS		4. DATE OF DEATH Month FEBRUARY Day 8 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired janitor		10b. KIND OF BUSINESS OR INDUSTRY Kelly-S. Tire Co. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Morris		14. MOTHER'S MAIDEN NAME Marion V. Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-0582	
17. INFORMANT Miss Martha Morris, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 Acute Leukemia - Lymphocytic. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mucous Colitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) XXX		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) XXX	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. XXX 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> XXX	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXX		20f. (City or town) (County) (State) XXX	
21. I certify that I attended the deceased from Jan. 11, 19 58 to Feb. 8, 19 58 , that I last saw the deceased alive on Feb. 8, 19 58 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 2/11/58			
ACTUAL SIGNATURE Martin Rothstein, M.D.		PHYSICIAN'S NAME (Type) Martin Rothstein, M. D. Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Frostburg, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
24b. REGISTRAR'S SIGNATURE Al. Leach			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 12 1969

RECEIVED

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1402 CERTIFICATE OF DEATH

01411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 MINUTES	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NIXON		4. DATE OF DEATH Month Day Year FEBRUARY 20 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 5
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JERRY NIXON		14. MOTHER'S MAIDEN NAME DONNA JEAN KERNS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost sowed the deceased olive on _____, 19____, and that death occurred at 6:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leland Kannon M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2-20-58	22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE FEB 24 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Alf Lewis	

2060171XV5

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU K. J.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1403

CERTIFICATE OF DEATH

Reg. Dist. No. 01412

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle E Last PETERMAN		4. DATE OF DEATH Month FEBRUARY Day 26 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Labor		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. PETERMAN		14. MOTHER'S MAIDEN NAME Minnie HEINTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Yes (If yes, give war or dates of service) War I		16. SOCIAL SECURITY NO. 359-09-7013	
17. INFORMANT Berdie Peterman		Address 435 Grand Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac enlargement and failure 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia and uremia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate with multiple metastasis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 Feb 1958 , to 26 Feb 1958 , that I last saw the deceased alive on Feb 25 1958 , and that death occurred at 8:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Baltimore Ave DATE SIGNED ACTUAL SIGNATURE Carlton Brinsfield M.D. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-1-58	22c. NAME OF CEMETERY OR CREMATORY St Lukes Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE MAR 3 '58	24b. REGISTRAR'S SIGNATURE Quinn

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1403

NAME OF DECEASED JAMES E. DAVIS		SEX MALE		AGE 35	
DATE OF DEATH MARCH 3, 1938		PLACE OF DEATH HOME		CITY BALTIMORE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		OCCUPATION CLERK	
DATE OF BIRTH MARCH 1, 1903		PLACE OF BIRTH BALTIMORE		PARENTS JAMES E. DAVIS, JR. & MARY E. DAVIS	
EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE MAY 15, 1925	
SPOUSE MARY E. DAVIS		CHILDREN JOHN E. DAVIS, JR. & MARY E. DAVIS, JR.		PREVIOUS DEATHS NONE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES JAMES E. DAVIS, JR. & MARY E. DAVIS, JR.		SIGNATURE OF PHYSICIAN DR. JAMES E. DAVIS, JR.	
DATE OF SIGNATURE MARCH 3, 1938		PLACE OF SIGNATURE HOME		CITY BALTIMORE	
STATE MARYLAND		COUNTY BALTIMORE		DISTRICT BALTIMORE	
REGISTRATION NUMBER 1403		DATE OF REGISTRATION MARCH 3, 1938		PLACE OF REGISTRATION BALTIMORE	

BUREAU V. 3

MAR 3 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1426

CERTIFICATE OF DEATH

Reg. Dist. No. 01413

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Nolan Picciani		4. DATE OF DEATH February 4 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Nolan		14. MOTHER'S MAIDEN NAME Elizabeth Downey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Daniel Fitzpatrick		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive Heart Failure DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1956 , to Feb 4, 1958 , that I last saw the deceased alive on Feb 4, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leslie R. Miles M.D.			
PHYSICIAN'S NAME (Type) Leslie R. Miles		Lonaconing, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/58	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR FEB 6 '58 24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES M. JONES		Male		35		1928	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main Street, Baltimore, Md.		Teacher		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TIME OF DEATH	
February 5, 1958		Home		10:00 AM		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 81

FEB 6 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1414

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 230 New Hampshire Ave.		d. STREET ADDRESS 230 New Hampshire Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Cynthia Middle Kay Last Plummer		4. DATE OF DEATH Month Feb. Day 16 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18-1957
		9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 4 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold O. Plummer		14. MOTHER'S MAIDEN NAME Tresa G. Sponaugle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address (father) Harold O. Plummer, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9210 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach contents. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH a few min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Baby found lying face down in crib, dead. Couple days before had a sore throat.	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. Feb. 16/58	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland Allegany Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 18-1958	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 20 '58	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1405

CERTIFICATE OF DEATH

01415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2yr, 3mo, 19da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle E. Last Price				4. DATE OF DEATH Month February Day 19 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John T. Noile				14. MOTHER'S MAIDEN NAME Elizabeth McGinnis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles R Price R.F.D.1 Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 454 Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 450 Cerebral arteriosclerosis DUE TO (c) 305 Presenile brain disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 31, 1955 , to Feb 19, 1958 , that I last saw the deceased alive on Feb 19, 1958 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Bruce St. 220-58			
PHYSICIAN'S NAME (Type) James E. McLean, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2.22.58		22c. NAME OF CEMETERY OR CREMATORY Buckvailey Christian		22d. LOCATION (City, town, or county) (State) Fulton County Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Moore Hancock Md				24a. REC'D BY REGISTRAR FEB 25 '58		24b. REGISTRAR'S SIGNATURE Arthur	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1909

RECEIVED
FEB 25 1959
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 Film 3225 2-26-58 et

1427

CERTIFICATE OF DEATH

01416

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Maple Street</u>				d. STREET ADDRESS <u>34 Maple St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>W.</u> Last <u>RACE</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Livestock Dealer</u>		11. BIRTHPLACE (State or foreign country) <u>Eckhart</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Race</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Botel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-3154</u>		17. INFORMANT <u>Ralph M. Race, Bealls Lane, Frostburg, Md.</u>		Address (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u> </u> (c) <u> </u> DUE TO Interval between onset and death <u>1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Feb 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>58</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Devers</u>		M.D. <u>John C. Devers</u>		ADDRESS (Street, city or town, state) <u>134 E. Main</u>		DATE SIGNED <u>2/20/58</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>		<u>Frostburg, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ben H. H. H. H.</u>		ADDRESS <u>23 E. Main, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE FEB 24 '58							

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

BUREAU W. B.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1437

CERTIFICATE OF DEATH

Reg. Dist. No. **01417**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ECKHART		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARY Middle V. Last REPHANN		4. DATE OF DEATH Month FEB. Day 23 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 30, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CONDON		14. MOTHER'S MAIDEN NAME ELLA RAFFERTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WM. H. REPHANN, ECKHART, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 x Diabetes		INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1957 , to Feb 23, 1958 , that I last saw the deceased alive on Feb 22, 1958 , and that death occurred at 6:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W O Mc Lane M.D.		ADDRESS (Street, city or town, state) E. MAIN ST., DATE SIGNED Feb 24 1958	
PHYSICIAN'S NAME (Type) W. O. MC LANE, M. D.		FROSTBURG, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-25-1958	22c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	22d. LOCATION (City, town, or county) (State) ECKHART, MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST, FROSTBURG, MD.		24a. REC'D BY REGISTRAR FEB 24 1958 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

RECEIVED
FEB 27 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1406

CERTIFICATE OF DEATH

Reg. Dist. No. 41418

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA. 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 2 JOHNS STREET	
3. NAME OF DECEASED (Type or print) First HOWARD Middle RALPH Last RHODES		4. DATE OF DEATH Month FEBRUARY Day 16 , Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13-1929
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill worker		10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEO RHODES		14. MOTHER'S MAIDEN NAME BERTIE ROWE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-38-8994	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH First 8-21-55	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-21-55 , 19 55 , to 2-16-58 , 19 58 , that I last saw the deceased alive on 2-15-58 , 19 58 , and that death occurred 6:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 2-17-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 20 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. F. Williams	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, with page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU 7 3

FEB 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01419

1407

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY d. STREET ADDRESS 85X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		WILLIAM		M.		ROOT	
4. DATE OF DEATH		Month		Day		Year	
		FEBRUARY		17		19 58	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 9 1915		42		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MACHINIST		POWDER CO.		THOMAS, W. VA.		U. S. A.	
13. FATHER'S NAME WILLIAM ROOT				14. MOTHER'S MAIDEN NAME REBECCA SHAHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		214-05-5854		MEMORIAL HOSPITAL		CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Artery Disease - Insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 minutes Aug 1957	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.1.17 , 19 58 , to 2.1.17 , 19 58 , that I last saw the deceased alive on 2.1.17 , 19 58 , and that death occurred at 7:25P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Topper				ADDRESS (Street, city or town, state)		DATE SIGNED 2/19/58	
PHYSICIAN'S NAME (Type) DR. JOHN TOPPER							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-20-1958		Queens Point Cemetery		Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF DECEASED

NAME OF WIFE

NAME OF HUSBAND

NAME OF MOTHER

NAME OF FATHER

NAME OF SISTER

NAME OF BROTHER

BUREAU V. 21

FEB 24 1958

RECEIVED

DR. JOHN JONES

1-30-1958

JOHN P. BENTLEY, JR.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01420

1408

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>811 Braddock Rd.</u>		d. STREET ADDRESS <u>811 Braddock Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Cecelia</u> Last <u>Schultz</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1891</u> 9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ocean Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac A. Caranough</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u> (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Wm. Harrison</u> Address <u>Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>58</u> , to <u>7/4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>58</u> , and that death occurred at <u>8:15 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo. H. Grey Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u> DATE SIGNED <u>7/6/58</u>	
PHYSICIAN'S NAME (Type) <u>LED H. LEX JR.</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

Name of Deceased <i>James A. Garmon</i>		Date of Death <i>Feb. 10, 1958</i>	
Age <i>68</i>		Sex <i>Male</i>	
Race <i>White</i>		Marital Status <i>Married</i>	
Usual Residence <i>211 Broadway St.</i>		Date of Birth <i>Dec. 1891</i>	
Cause of Death <i>Heart Disease</i>		Date of Death <i>Feb. 10, 1958</i>	
Place of Death <i>Home</i>		Signature of Physician <i>Wm. H. Harrison</i>	
Signature of Informant <i>Wm. H. Harrison</i>		Date of Report <i>Feb. 10, 1958</i>	

BUREAU V. S.

FEB 10 1958

RECEIVED

Name of Informant <i>Wm. H. Harrison</i>	Address of Informant <i>211 Broadway St.</i>
Signature of Informant <i>Wm. H. Harrison</i>	Date of Report <i>Feb. 10, 1958</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1409

CERTIFICATE OF DEATH

01421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/5/52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mattie Middle C. Last Simmons		4. DATE OF DEATH Month February Day 26 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Owen McCullough		14. MOTHER'S MAIDEN NAME Belle Rexroad	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Pulmonary Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis. (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/5/52 , 19 52 , to 2/26/58 , 19 58 , that I last saw the deceased alive on 2/26/58 , 19 58 , and that death occurred at 5:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 2/27/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 Mar. 58	
22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		22d. LOCATION (City, town, or county) (State) Dawson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen Rotun ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
24b. REGISTRAR'S SIGNATURE Allen Rotun			

BUREAU V.

1958 5 11

RECEIVED

1410 CERTIFICATE OF DEATH

Reg. Dist. No. 01422

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keyser Rt. # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Along Rt. # 220</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>William</u> Last <u>Skelley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Bedford Co.</u>	
12. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Skelley</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-1846-4</u>	
17. INFORMANT <u>Mr. Samuel L. Skelley</u>		Address <u>Rt. # 3 Keyser, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of ascending colon</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>56</u> , to <u>2-25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Prince</u>		ADDRESS (Street, city or town, state) <u>57 Greene St., Cumberland</u> DATE SIGNED <u>2-27-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. L. Prince</u>		<u>57 Greene Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>MAR 3 '58</u>		<u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. E.

MAR 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1411

CERTIFICATE OF DEATH

Reg. Dist. No.

01423

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 819 Bedford St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1. d. STREET ADDRESS 819 Bedford St.			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle I. Last SMITH				4. DATE OF DEATH Month Feb. Day 13 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wright				14. MOTHER'S MAIDEN NAME Estelle Korns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ethel Johnson, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X acute cerebro-vascular accident DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 12 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/1/58 , 19____, to 2/13/58 , 19____, that I last saw the deceased alive on 2/14/58 , 19____, and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Lopper M.D.				ADDRESS (Street, city or town, state) Hyndman Pa DATE SIGNED 2/14/58			
PHYSICIAN'S NAME (Type) John A. Lopper							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR FEB 18 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White		DATE OF BIRTH 12-1-29		PLACE OF BIRTH Memphis, Tenn.	
MARRIAGE Married		SPOUSE'S NAME Jane Ann Ray		SPOUSE'S AGE 32		SPOUSE'S SEX Female		SPOUSE'S RACE White		SPOUSE'S DATE OF BIRTH 11-1-27	
OCCUPATION Author		EDUCATION High School		RELIGION Methodist		MILITARY SERVICE None		NAVY SERVICE None		ARMY SERVICE None	
DATE OF DEATH 4-4-68		PLACE OF DEATH London, England		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN Jane Ann Ray		SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF CORONER Mr. John Doe		SIGNATURE OF REGISTRAR Miss Mary White		SIGNATURE OF CLERK Mr. John Doe	

BUREAU V. 21

FEB 18 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1412

CERTIFICATE OF DEATH

01424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle Frances Last SMITH				4. DATE OF DEATH Month FEBRUARY Day 28 Year 19 58.			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1889	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND, Westernport		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS RUCKMAN				14. MOTHER'S MAIDEN NAME ZULEMA HAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8223B		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerosis DUE TO 2-18-58 (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 2-18-58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-11-37 to 2-28, 1958 , that I last saw the deceased alive on 2-28, 1958 , and that death occurred at 6:48 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. J. Williams		M.D. Cumberland Md		ADDRESS (Street, city or town, state) 122 So. Center St.,		DATE SIGNED 3-2-58	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/3/58	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1428

CERTIFICATE OF DEATH

Reg. Dist. No. 1425

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SARAH First STARK Middle Last				4. DATE OF DEATH Month 2 Day 25 Year 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) Frostburg	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William Morgan			
14. MOTHER'S MAIDEN NAME Mary Jane Wilcox				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None None			
16. SOCIAL SECURITY NO. None				17. INFORMANT (Son) William J. Stark, 112 Mt. Pleasant St., Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 20 yrs.? INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) XXX				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) XXX			
20c. TIME OF INJURY Hour a. m. XXX 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXX		20f. (City or town) XXX (County) (State)	
21. I certify that I attended the deceased from 2/23/58 , 19 58 , to 2/25/58 , 19 58 , that I last saw the deceased alive on 2/25/58 , 19 58 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 2/25/58							
ACTUAL SIGNATURE Martin M. Rothstein M.D.				PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesant				ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR Alfred	
DATE MAR 3 '58				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAR 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01426

1413

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE BALTIMORE PIKE b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 8 HOURS 28 Min. X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 2, CUMBERLAND, MD		
d. NAME OF HOSPITAL (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle STEGMAIER Last STEGMAIER				4. DATE OF DEATH Month FEBRUARY Day 4 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 27 Days 73 Hours 73 Min.		IF UNDER 24 HRS. Months 27 Days 73 Hours 73 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEONARD STEGMAIER				14. MOTHER'S MAIDEN NAME GERTRUDE HOOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rose Stegmaier Route 2, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Acute Myelogenous Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 260x DUE TO Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x DUE TO Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH Out walk			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-2-58 to 2-4-58 , that I last saw the deceased alive on 2-4-58 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. R. Johnson		M.D. Cumberland, Md.		DATE SIGNED 2-5-58			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/1958		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Pauls Ce.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
				24b. REGISTRAR'S SIGNATURE W. J. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the attending physician and completely filled out by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

511

BUREAU V. S.

FEB 10 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01427

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 22 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Edgar Last Stephens		4. DATE OF DEATH Month Feb. Day 10 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12-1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Electrician Contractor		10b. KIND OF BUSINESS OR INDUSTRY Altoona, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Stephens		14. MOTHER'S MAIDEN NAME Maria Reem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-6040	
17. INFORMANT Marion Rosenmerkle, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage due to a lacerated 976x DUE TO (b) brain from a 22 caliber rifle bullet in Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) head, self inflicted. about 28 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) about 28 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot himself in right temporal region with a 22 rifle.	
20c. TIME OF INJURY Month, Day, Year Feb. 8 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rawling, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 10-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Altoona Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stui Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR DATE FEB 13 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

STATE OF MASS.
HEALTH DEPT.
B

RECEIVED
FEB 13 1959
BUREAU V. 8

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

Chief of Police
[illegible]
[illegible]
[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1429 CERTIFICATE OF DEATH

Reg. Dist. No. **01428**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Centennial St. ext.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle (GREEN) Last THORPE		4. DATE OF DEATH Month FEBRUARY Day 14 , Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1958
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Green		14. MOTHER'S MAIDEN NAME Rebecca Poland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-6519	
17. INFORMANT Mrs. Bessie Andrews, Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4.4 hrs. Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan , 19 58 , to Feb 14 , 19 58 , that I last saw the deceased alive on Feb 8 , 19 58 , and that death occurred at 12:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Broadway, DATE SIGNED _____ ACTUAL SIGNATURE John B. Davis , M.D. PHYSICIAN'S NAME (Type) John B. Davis, M. D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-17-1958	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) _____ (State) _____ Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR FEB 18 '58		24b. REGISTRAR'S SIGNATURE Rev. [Signature]	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 18 1938

BUREAU V. S.

CERTIFICATE OF DEATH

TWIN BROS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01429

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Savage Rd.				d. STREET ADDRESS Mt. Savage Rd.			
3. NAME OF DECEASED (Type or print) First Andrew Middle Talbert Last Valentine				DATE OF DEATH Month Feb. Day 5 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14-1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James V. Valentine				14. MOTHER'S MAIDEN NAME Anner Welsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address (wife) Sylvia Valentine, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis with hypertention (c) ?						INTERVAL BETWEEN ONSET AND DEATH Gradual about 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 5-1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Savage Cem.		22d. LOCATION (City, town, or county) (State) Mt. Savage Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
						24b. REGISTRAR'S SIGNATURE W. J. ...	

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
A. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 10 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director, and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01430

1415 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/2/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
3. NAME OF DECEASED (Type or print) First Ernestine Middle Viva Last Wittig		d. STREET ADDRESS 90 Frost Avenue	
4. DATE OF DEATH Month February Day 11 , Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1888
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 69 Days 11 Hours 19 Min. 58	IF UNDER 24 HRS. Months 69 Days 11 Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Novelty		10b. KIND OF BUSINESS OR INDUSTRY Shop Keeper	
11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Henry Wittig		14. MOTHER'S MAIDEN NAME Elizabeth Wieghorst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 215-20-6861-A		16. SOCIAL SECURITY NO. 215-20-6861-A	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO ? (c) Coronary Arteriosclerosis DUE TO ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/2/57 , 19____, to 2/11/58 , 19____, that I last saw the deceased alive on 2/10/58 , 19____, and that death occurred at 2:42P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 2/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/58	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Basil H. Montesant		24a. REC'D BY REGISTRAR FEB 18 58	
ADDRESS Hafer Funeral Home		24b. REGISTRAR'S SIGNATURE West	
23 E. Main, Frostburg, Md.		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01431**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany 1416		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 313 Avirett Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Yaksetich Last Yaksetich		4. DATE OF DEATH Month Feb. Day 4 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19-1878
9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store.	
11. BIRTHPLACE (State or foreign country) Yugoslavia.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT S.H.H. record.		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis also malnutrition & emaciation.			INTERVAL BETWEEN ONSET AND DEATH sudden ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Feb. 4-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/58	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR FEB 10 '58	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Over...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1933

BUREAU V. S.

STATE DEPARTMENT OF HEALTH - BATHING 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
BIRTH: [illegible]
DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

NEW STATE
HEALTH DEPT